COLUMBIA BASIN EYE CLINIC PS

PATIENT'S INFORMATION: (Please fill form out completely) **Today's Date: __________________**

Last Name ____________ First Name ____________ MI ______ Date of Birth _____-_____-______ Age ________

Social Security Number _________-_____-_________

Circle one: Marital Status: Married / Widowed/ Single/ Other

Occupation / Retired? ________________ Employer ________________________

Preferred Language: Other? English/ Spanish/__________

Contact Preference : (Circle) Mail / Phone/ Email/Text Message

Would you like email updates? If so please give Email Address YES / NO ______________________________

Gender: Male / Female **Race:** White /African Amer/Amer Indian/ Asian / Hispanic-Latino/ other? ______________

Ethnicity: American / Mexican / Japanese / Chinese/ Asian / European / Latino/ other? ______________________

Patient's Mailing Address/ & Home Address ____________________ City ____________ State ________ Zip code ________

Home Phone (_____)____________ Work Phone/ Extension (_____)____________ Cell Phone (______)__________ Alt. Phone #/ Who's Number or Type? ____________________

Patient's Employer Address ____________________ City ____________ State / Zip ____________ Phone Number (____)____________

Spouse's Full name ____________________ Spouse's SSN # _____-_____-______ Spouse's DOB ___-___-______ Spouse's Age ________ Spouse's Cell # (____)________

Spouse's Employer ____________ Spouse's Employer Address ____________________ City ____________ State/Zip ____________ Spouse's Work # (____)________

DO YOU HAVE AN "ADVANCED DIRECTIVE?:

Circle: YES or NO

Circle Type of Directive: Living Will / Organ-Tissue Donor / Durable Power of Attorney / Do Not Recessutate (DNR)

REFERRED BY: Yellow pages / Radio / Newspaper / Internet / Friend / Dr. __________ / Other: ______________

Circle or Fill in Name of referring Source

EMERGENCY CONTACT : (IF UNABLE TO REACH PATIENT)

Name ____________________ Relationship ____________ Home Phone (___)__________ Cell Phone (___) ___________ Work Phone / Extension (___) ______________

IF PATIENT IS A MINOR: PLEASE COMPLETE):

Mother's Full Name ____________________ Social Security # _______ - _____ - ________ Date of Birth ______________ Phone # Cell or Home? (___)________________

Mother's Employer ____________________ Work Phone # and Ext (____) ____________ Home Address if different from Above ____________________

Father's Full Name ____________________ Social Security # _______ - _____ - ________ Date of Birth ______________ Phone # Cell or Home? (___)________________

Father's Employer ____________________ Work Phone # and Ext (____) ____________ Home Address if different from Above ____________________

COMPLETE OTHER SIDE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST TO COPY

PHARMACY INFORMATION:

Preferred Pharmacy	Street Address	City	State	( ) Phone #

PHYSICIAN INFORMATION:

Primary Care Physician	Street Address	City	State	( ) Phone #
Other Physician's Name and Specialty	Street Address	City	State	( ) Phone #
Other Physician's Name and Specialty	Street Address	City	State	( ) Phone #

INSURANCE INFORMATION: (Please give insurance cards to receptionist to copy)

Primary: ______________ **Subscriber:** ____________________ **Birthdate:**_______________

Secondary: ______________ **Subscriber:** ____________________ **Birthdate:**_______________

Third: ________________ **Subscriber:** ____________________ **Birthdate:**_______________

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION:

I authorize my physician and/or administrative and clinical staff of Columbia Basin Eye Clinic PS to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Columbia Basin Eye Clinic PS.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, friend)

Name of Person or Entity:	Relationship:

THE FORMS MENTIONED BELOW ARE AVAILABLE ON THE CENTER CONSOLE IN THE WAITING ROOM.

I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to read and understand and consent to Columbia Basin Eye Clinic's use and disclosure of protected health information about myself for treatment, payment and health care operations.

________________________________ **Signature of the Patient or Patient Representative**

I have been provided a copy of the CBEC Financial Policy to read. I understand, that I, the patient or the patient's representative, am/is responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

________________________________ **Signature of the Patient or Patient Representative**

I authorize the release of any medical information necessary to process all claims and I authorize the release of payment for medical benefits to Columbia Basin Eye Clinic PS.

________________________________ **Signature of the Patient or Patient Representative**